		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0039347

Facility Name: Montgomery Nursing and Rehabilitation Ctr

Address: South Route 127, P.O. Box 309 (Number) Hillsboro (City) 62049 (Zip Code)

County: Montgomery

Telephone Number: (217) 532-6126 **Fax #** (217) 532-9465

IDPA ID Number: 37-1323740

Date of Initial License for Current Owners: 04/01/1994

Type of Ownership:

	VOLUNTARY,NON-PROFIT	x	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		x	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: J. Terry Dooling **Telephone Number:** (618) 465-7717

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2002 to 12/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) J. Terry Dooling
(Title) Treasurer

Paid Preparer

(Signed) See Accountants' Compilation Report (Date)
(Print Name and Title) J. Terry Dooling, Partner
(Firm Name & Address) C.J. Schlosser & Company, L.L.C, 233 East Center Drive, Alton, IL 62002
(Telephone) (618) 465-7717 Fax # (618) 465-7710

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing and Rehabilitation Ctr # 0039347 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	21	Skilled (SNF)	21	7,665	1
2		Skilled Pediatric (SNF/PED)			2
3	80	Intermediate (ICF)	80	29,200	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	101	TOTALS	101	36,865	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,125	1,622	2,499	7,246	8
9	SNF/PED					9
10	ICF	11,899	6,177		18,076	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,024	7,799	2,499	25,322	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.69%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [x]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 4/01/94

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 4/01/94 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 12 and days of care provided 2,499

Medicare Intermediary Trispan Health Services

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/2002 Fiscal Year: 12/31/2002

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Montgomery Nursing and Rehabilitation Ctr # 0039347 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	143,857	8,993	4,974	157,824		157,824		157,824			1
2	Food Purchase		111,244		111,244		111,244	(303)	110,941			2
3	Housekeeping	72,897	11,839		84,736		84,736		84,736			3
4	Laundry	49,741	8,966		58,707		58,707		58,707			4
5	Heat and Other Utilities			75,278	75,278		75,278	526	75,804			5
6	Maintenance	38,401	4,851	30,125	73,377	228	73,605	589	74,194			6
7	Other (specify):* Waste Removal			2,920	2,920		2,920		2,920			7
8	**TOTAL General Services**	304,896	145,893	113,297	564,086	228	564,314	812	565,126			8
	B. Health Care and Programs											
9	Medical Director			8,800	8,800		8,800		8,800			9
10	Nursing and Medical Records	843,518	54,399	4,005	901,922	250	902,172		902,172			10
10a	Therapy		3,389	159,799	163,188		163,188	(15,491)	147,697			10a
11	Activities	37,560	3,100	2,365	43,025		43,025		43,025			11
12	Social Services	26,506	(26)	2,584	29,064		29,064		29,064			12
13	Nurse Aide Training					521	521		521			13
14	Program Transportation		1,282		1,282		1,282		1,282			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	907,584	62,144	177,553	1,147,281	771	1,148,052	(15,491)	1,132,561			16
	C. General Administration											
17	Administrative	51,102	4,747	132,806	188,655	(478)	188,177	(16,728)	171,449			17
18	Directors Fees											18
19	Professional Services			36,809	36,809		36,809	22,429	59,238			19
20	Dues, Fees, Subscriptions & Promotions			36,197	36,197	(368)	35,829	(26,254)	9,575			20
21	Clerical & General Office Expenses	57,022	14,326	34,045	105,393	126	105,519	12,197	117,716			21
22	Employee Benefits & Payroll Taxes			202,140	202,140		202,140	10,381	212,521			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,129	6,129	(153)	5,976	68	6,044			24
25	Other Admin. Staff Transportation							2,955	2,955			25
26	Insurance-Prop.Liab.Malpractice			51,717	51,717		51,717	2,687	54,404			26
27	Other (specify):*											27
28	**TOTAL General Administration**	108,124	19,073	499,843	627,040	(873)	626,167	7,735	633,902			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,320,604	227,110	790,693	2,338,407	126	2,338,533	(6,944)	2,331,589			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Montgomery Nursing and Rehabilitation Ctr #0039347 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			104,866	104,866		104,866	4,889	109,755			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			218,158	218,158		218,158	(21,569)	196,589			32
33	Real Estate Taxes			32,369	32,369		32,369	547	32,916			33
34	Rent-Facility & Grounds							4,101	4,101			34
35	Rent-Equipment & Vehicles			1,038	1,038	(126)	912	759	1,671			35
36	Other (specify):* **Mortgage Ins.**			11,883	11,883		11,883		11,883			36
37	**TOTAL Ownership**			368,314	368,314	(126)	368,188	(11,273)	356,915			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		54,772	16,248	71,020		71,020		71,020			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			55,297	55,297		55,297		55,297			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		54,772	71,545	126,317		126,317		126,317			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,320,604	281,882	1,230,552	2,833,038		2,833,038	(18,217)	2,814,821			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing and Rehabilitation Ctr # 0039347 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(303)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(1,351)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(260)	17		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(1,011)	24		19
20	Contributions	(2,650)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(20,111)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(12,398)	Var		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (38,084)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	19,867		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 19,867		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (18,217)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Montgomery Nursing and Rehabilitation Ctr

ID# 0039347

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Eliminate Chamber of Commerce dues	$ (199)	20	1
2	Offset expense reimbursements	(8)	21	2
3	Eliminate PAC & lobbying dues	(3,361)	20	3
4	Add Back 2002 IDPH license pd in 2001	200	20	4
5	Offset medicare billing income from other income	(6,900)	21	5
6	Eliminate 2003/2004 IDPH license paid in 2002	(400)	20	6
7	Eliminate non-care related seminar	(1,425)	24	7
8	Eliminate additional sales tax paid	(305)	20	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(12,398)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Montgomery Nursing and Rehabilitation Ctr **#** 0039347 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(303)	0	0	0	0	0	0	0	0	0	0	(303)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	526	0	0	0	0	0	0	0	0	0	526	5
6	Maintenance	0	589	0	0	0	0	0	0	0	0	0	589	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(303)	1,115	0	0	0	0	0	0	0	0	0	812	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	(15,491)	0	0	0	0	0	0	0	0	(15,491)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	(15,491)	0	0	0	0	0	0	0	0	(15,491)	16
	C. General Administration													
17	Administrative	(260)	116,338	(132,806)	0	0	0	0	0	0	0	0	(16,728)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	636	21,793	0	0	0	0	0	0	0	0	22,429	19
20	Fees, Subscriptions & Promotions	(26,826)	572	0	0	0	0	0	0	0	0	0	(26,254)	20
21	Clerical & General Office Expenses	(6,908)	19,105	0	0	0	0	0	0	0	0	0	12,197	21
22	Employee Benefits & Payroll Taxes	0	10,381	0	0	0	0	0	0	0	0	0	10,381	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(2,436)	2,504	0	0	0	0	0	0	0	0	0	68	24
25	Other Admin. Staff Transportation	0	2,955	0	0	0	0	0	0	0	0	0	2,955	25
26	Insurance-Prop.Liab.Malpractice	0	2,687	0	0	0	0	0	0	0	0	0	2,687	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(36,430)	155,178	(111,013)	0	0	0	0	0	0	0	0	7,735	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(36,733)	156,293	(126,504)	0	0	0	0	0	0	0	0	(6,944)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Montgomery Nursing and Rehabilitation Ctr** **#** **0039347** **Report Period Beginning:** **01/01/2002** **Ending:** **12/31/2002**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	4,889	0	0	0	0	0	0	0	0	0	4,889	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,351)	69	(20,287)	0	0	0	0	0	0	0	0	(21,569)	32
33	Real Estate Taxes	0	547	0	0	0	0	0	0	0	0	0	547	33
34	Rent-Facility & Grounds	0	0	4,101	0	0	0	0	0	0	0	0	4,101	34
35	Rent-Equipment & Vehicles	0	0	759	0	0	0	0	0	0	0	0	759	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(1,351)	5,505	(15,427)	0	0	0	0	0	0	0	0	(11,273)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(38,084)	161,798	(141,931)	0	0	0	0	0	0	0	0	(18,217)	45

Facility Name & ID Number Montgomery Nursing and Rehabilitation Ctr # 0039347 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
John H. Rothert	60.00	Jerseyville Nursing and Rehabilitation Ctr, Inc.	Jerseyville, Il	Wellington Mgmt Co	Chesterfield, MO	Management Co
David L. Kamler	10.00	Westwood Hills Health Care Center	Poplar Bluff, MO	Health Care Financial	Alton	Management Co
J. Terry Dooling	10.00			C.J. Schlosser & Co.	Alton	Public Accountants
R.J. Tolliver	10.00			NW Rehab, L.L.C.	Alton	Therapy Co
Jack A. Yeager	10.00					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	See Schedule VIII	$	Wellington Management Co	60.00%	$ 526	$ 526	1
2	V	6	See Schedule VIII		Wellington Management Co	60.00%	589	589	2
3	V	17	See Schedule VIII		Wellington Management Co	60.00%	116,338	116,338	3
4	V	19	See Schedule VIII		Wellington Management Co	60.00%	636	636	4
5	V	20	See Schedule VIII		Wellington Management Co	60.00%	572	572	5
6	V	21	See Schedule VIII		Wellington Management Co	60.00%	19,105	19,105	6
7	V	22	See Schedule VIII		Wellington Management Co	60.00%	10,381	10,381	7
8	V	24	See Schedule VIII		Wellington Management Co	60.00%	2,504	2,504	8
9	V	25	See Schedule VIII		Wellington Management Co	60.00%	2,955	2,955	9
10	V	26	See Schedule VIII		Wellington Management Co	60.00%	2,687	2,687	10
11	V	30	See Schedule VIII		Wellington Management Co	60.00%	4,889	4,889	11
12	V	32	See Schedule VIII		Wellington Management Co	60.00%	69	69	12
13	V	33	See Schedule VIII		Wellington Management Co	60.00%	547	547	13
14	Total			$			$ 161,798	$ * 161,798	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing and Rehabilitation Ctr # 0039347 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	See Schedule VIII	$	Wellington Management Co.	60.00%	$ 4,101	$ 4,101	15
16	V	35	See Schedule VIII		Wellington Management Co.	60.00%	759	759	16
17	V	17	Management Fees	95,620	Wellington Management Co.	60.00%		(95,620)	17
18	V	17	Management Fees	37,186	Health Care Financial, LLC	40.00%		(37,186)	18
19	V	19	Professional Services	27,838	CJ Schlosser & Company, LLC	40.00%	49,631	21,793	19
20	V	10a	Therapy Services	159,799	NW Rehab, LLC	100.00%	144,308	(15,491)	20
21	V	32	Interest	7,600	Health Care Financial, LLC	40.00%	4,091	(3,509)	21
22	V	32	Interest	16,778	John H. Rothert	60.00%		(16,778)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 344,821			$ 202,890	$ * (141,931)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing and Rehabilitation Ct # 0039347 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	John H. Rothert	President	Administrative	60.00	316,602	9.43	24.00	Salary	$ 97,665	17,8	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 97,665		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing and Rehabilitation Ctr # 0039347 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Wellington Management Company
Street Address: 750 Spirit 40 Park Drive
City / State / Zip Code: Chesterfield, MO 63005
Phone Number: (636-537-8447
Fax Number: (636-847-5446

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Heat and Other Utilities	Accumulated Costs	11,459,967	4	$ 2,231	$	2,701,739	$ 526	1
2	6	Maintenance	Accumulated Costs	11,459,967	4	2,497		2,701,739	589	2
3	17	Administrative	Accumulated Costs	11,459,967	4	493,470	493,470	2,701,739	116,338	3
4	19	Professional Services	Accumulated Costs	11,459,967	4	2,698		2,701,739	636	4
5	20	Dues, Fees, Subscriptions and Pro	Accumulated Costs	11,459,967	4	2,425		2,701,739	572	5
6	21	Clerical and General Office Exp	Accumulated Costs	11,459,967	4	81,036	43,131	2,701,739	19,105	6
7	22	Employee Benefits and PR Taxes	Accumulated Costs	11,459,967	4	44,032		2,701,739	10,381	7
8	24	Travel and Seminar	Accumulated Costs	11,459,967	4	10,621		2,701,739	2,504	8
9	25	Other Admin Staff Transport	Accumulated Costs	11,459,967	4	12,535		2,701,739	2,955	9
10	26	Insurance-Prop.,Liab.,Malprac	Accumulated Costs	11,459,967	4	11,398		2,701,739	2,687	10
11	30	Depreciation	Accumulated Costs	11,459,967	4	20,737		2,701,739	4,889	11
12	32	Interest	Accumulated Costs	11,459,967	4	294		2,701,739	69	12
13	33	Real Estate Taxes	Accumulated Costs	11,459,967	4	2,321		2,701,739	547	13
14	34	Rent-Facility & Grounds	Accumulated Costs	11,459,967	4	17,395		2,701,739	4,101	14
15	35	Rent-Equipment & Vehicles	Accumulated Costs	11,459,967	4	3,221		2,701,739	759	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 706,911	$ 536,601		$ 166,658	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing and Rehabilitation Ctr # 0039347 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	GMAC Commerical Mortgage		x	Refinance Mortgage	$17,016.17	09/29/99	$ 2,415,500	$ 2,367,913	10/01/34	7.9200	$ 188,232	1
2												2
3								Loan Cost Amortization			4,664	3
4								Home Office Allocation			69	4
5								Interest Income			(1,351)	5
	Working Capital											
6	Health Care Financial, LLC	x		Working Capital	N/A	9/1/97	80,000	80,000	9/1/07	9.5000	4,091	6
7	First National Bank		x	Line of Credit	N/A	01/04/02	100,000	90,001	01/04/03	5.7500	884	7
8												8
9	TOTAL Facility Related				$17,016.17		$ 2,595,500	$ 2,537,914			$ 196,589	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,595,500	$ 2,537,914			$ 196,589	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 11,883 Line # 36

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Montgomery Nursing and Rehabilitation Ctr # 0039347 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	30,500	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	31,369	2
3. Under or (over) accrual (line 2 minus line 1).	$	869	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$	31,500	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	32,369	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1997	26,834	8
1998	26,955	9
1999	28,716	10
2000	30,459	11
2001	31,369	12

Line 2: 2001 Taxes Paid

Line 4: Accrual is based on 2001 taxes paid.

Line 7: $32,369 + $547 (Home Office R.E Tax Allocation) = $32,916 Total R.E. Taxes-Schedule V, Col. 8

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Montgomery Nursing and Rehabilitation Ctr COUNTY Montgomery

FACILITY IDPH LICENSE NUMBER 0039347

CONTACT PERSON REGARDING THIS REPORT J. Terry Dooling

TELEPHONE (618) 465-7717 FAX #: (618) 465-7710

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-100-716-75	NE PT SE SW	$ 31,368.82	$ 31,368.82
2.		Land Corp Limit Taylor Springs	$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 31,368.82	$ 31,368.82

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number Montgomery Nursing and Rehabilitation Ctr # 0039347 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 27,192 B. General Construction Type: Exterior Brick Frame Steel & Brick Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs: N/A
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	348,480	1994	$ 27,673	1
2					2
3	TOTALS	348,480		$ 27,673	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing and Rehabilitation Ctr # 0039347 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	101		1994		$ 962,086	$ 38,483	25	$ 38,483	$	$ 336,730	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Shed			1994	3,247	325	10	325		2,760	9
10	Air Conditioner			1994	76,140	7,614	10	7,614		64,719	10
11	Cabinets			1994	6,809	340	20	340		2,809	11
12	Doors			1994	2,337	117	20	117		974	12
13	Electrical			1994	4,601	230	20	230		1,874	13
14	Flooring			1994	25,850	2,585	10	2,585		21,517	14
15	Exterior Remodeling			1994	4,468	298	15	298		2,482	15
16	Interior Remodeling			1994	66,214	4,428	15	4,428		36,121	16
17	Nurse Call System			1994	1,960	131	15	131		1,078	17
18	Plumbing			1994	6,619	331	20	331		2,722	18
19	Roof			1994	29,619	2,962	10	2,962		24,927	19
20	Windows/Gutters			1994	60,254	4,017	15	4,017		33,809	20
21	Siding			1994	15,818	1,054	15	1,054		8,510	21
22	Landscaping			1994	3,134	313	10	313		2,638	22
23	Parking Lot			1994	29,107	2,911	10	2,911		24,657	23
24	Home Office Wallpapering/Flooring			1994	3,727		5			3,727	24
25	Flooring			1995	938	94	10	94		751	25
26	Metal Doors and Frames			1996	953	48	20	48		310	26
27	Metal Carport			1997	972	65	15	65		340	27
28	Carpet			1997	2,310	385	5	385		2,310	28
29	Dining Room Chair Rail			1997	2,230	149	15	149		743	29
30	Wallpapering			1997	4,830	885	5	885		4,830	30
31	Fire Doors			1997	593	30	20	30		148	31
32	Foliage & Fountains			1997	1,657	166	10	166		953	32
33	Interior Painting			1997	514	94	5	94		514	33
34	Shed			1997	315	32	10	32		160	34
35	Door Alarm System			1997	7,840	784	10	784		3,986	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Montgomery Nursing and Rehabilitation Ctr # 0039347 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Sidewalk Replacement	1997	$ 650	$ 43	15	$ 43	$	$ 220	37
38	Beauty Shop Remodeling	1998	4,287	214	20	214		911	38
39	Wallpapering	1998	1,493	299	5	299		1,417	39
40	Shower Room Remodeling	1998	1,199	60	20	60		260	40
41	Mini Blinds Installed	1998	509	51	10	51		249	41
42	Shelving	1998	566	28	20	28		124	42
43	Baseboard Remodeling	1998	820	82	10	82		403	43
44	Water Heater	1998	6,040	403	15	403		1,711	44
45	Folding Doors	1998	456	45	10	45		194	45
46	Door Installed	1998	208	21	10	21		87	46
47	Wall Mounted Laundry Tub	1998	181	9	20	9		45	47
48	Shower Flooring	1998	401	40	10	40		164	48
49	Shed	1998	185	19	10	19		76	49
50	Flooring	1998	293	29	10	29		129	50
51	Air conditioning Unit	2000	557	56	10	56		144	51
52	Asphalt Parking Lot	2000	2,360	236	10	236		551	52
53	Fire Doors	2001	1,534	102	15	102		162	53
54	Signage	2001	3,318	664	5	664		1,051	54
55	Cove Base	2001	1,006	101	10	101		157	55
56	Window Treatments	2001	7,272	1,454	5	1,454		2,303	56
57	Wallpapering	2001	37,693	7,538	5	7,538		11,888	57
58	Lobby Carpet	2001	1,433	286	5	286		478	58
59	Air Conditioner	2001	1,696	170	10	170		254	59
60	Home Office Wallpapering	1999	627		5	125	125	481	60
61	Cove Base	2002	604	10	10	10		10	61
62	Wallpapering	2002	4,462	662	5	662		662	62
63	Air Conditioner	2002	1,981	132	10	132		132	63
64	Blinds	2002	512	94	5	94		94	64
65	Flooring & Cave Base	2002	1,630	149	10	149		149	65
66	Wall Guard	2002	1,927	107	15	107		107	66
67	Fire Doors	2002	1,042	35	15	35		35	67
68	AC/Heat Pump Units	2002	1,580	66	10	66		66	68
69	Home Office Light Fixtures	2002	227		10	21	21	21	69
70	TOTAL (lines 4 thru 69)		$ 1,413,891	$ 82,076		$ 82,222	$ 146	$ 611,834	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Montgomery Nursing and Rehabilitation Ctr # 0039347 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 172,621	$ 17,698	$ 19,364	$ 1,666	5-20	$ 66,255	71
72	Current Year Purchases	25,909	2,169	2,345	176	5-15	2,345	72
73	Fully Depreciated Assets	266,421	1,026	1,112	86	5	266,421	73
74								74
75	TOTALS	$ 464,951	$ 20,893	$ 22,821	$ 1,928		$ 335,021	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Use	1997 Minivan	2000	$ 7,589	$ 1,897	$ 1,897	$	4	$ 4,269	76
77	Home Office -Admin	2000 Taurus	2000	5,615		1,404	1,404	4	3,275	77
78	Home Office -Admin	1997 Jaguar-Disposed 2002	2000			1,345	1,345	4		78
79	Home Office -Admin	1992 Minivan-Disposed 2002	2000			66	66	4		79
80	TOTALS			$ 13,204	$ 1,897	$ 4,712	$ 2,815		$ 7,544	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,919,719	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 104,866	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 109,755	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 4,889	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 954,399	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Section Not Applicable	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Section Not Applicable	$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Section Not Applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? N/A YES N/A NO

16. Rental Amount for movable equipment: $ 912 Description: Ice Machine Rental - $876, Gas Tank-$36
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Section Not Applicable		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing and Rehabilitation Ctr # 0039347 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [x] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [x]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 80

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [x]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 40

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		121		121
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests		400		400
9	TOTALS	$	$ 521	$	$ 521
10	SUM OF line 9, col. 1 and 2 (e)	$ 521			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	8
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	8

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a,8	1929 hrs	$ 52,882		$	$ 1,046	1,929	$ 53,928	1
2	Licensed Speech and Language Development Therapist	10a,8	1057 hrs	34,401				1,057	34,401	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,8	2233 hrs	57,025			2,343	2,233	59,368	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39,2	# of prescrpts				54,772		54,772	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Laboratory Fees Other (specify): X-Rays	39,3 39,3				13,923 2,325			13,923 2,325	13
14	TOTAL			$ 144,308		$ 16,248	$ 58,161	5,219	$ 218,717	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing and Rehabilitation Ctr # 0039347 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2002 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 151,799	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 25,000)	501,695		3
4	Supply Inventory (priced at cost)	10,443		4
5	Short-Term Investments			5
6	Prepaid Insurance	21,026		6
7	Other Prepaid Expenses	8,664		7
8	Accounts Receivable (owners or related parties)	10,179		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 703,806	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	30,300		12
13	Land	62,924		13
14	Buildings, at Historical Cost	1,374,060		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	458,164		16
17	Accumulated Depreciation (book methods)	(937,327)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	93,217		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Loan Costs	148,069		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,229,407	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,933,213	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 479,112	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	98,361		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,486		31
32	Accrued Real Estate Taxes(Sch.IX-B)	31,500		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Related Parties	326,837		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 948,296	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	282,793		39
40	Mortgage Payable	2,367,913		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,650,706	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,599,002	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,665,789)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,933,213	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Montgomery Nursing and Rehabilitation Ctr # 0039347 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,475,886)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,475,886)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(189,903)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (189,903)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,665,789)	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing and Rehabilitation Ctr # 0039347 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,298,572	1
2	Discounts and Allowances for all Levels	24,060	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,322,632	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	291,720	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 291,720	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	530	11
12	Gift and Coffee Shop	315	12
13	Barber and Beauty Care	672	13
14	Non-Patient Meals	303	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	11,752	19
20	Radiology and X-Ray	542	20
21	Other Medical Services		21
22	Laundry	(2)	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 14,112	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,351	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,351	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	13,320	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 13,320	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,643,135	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	564,086	31
32	Health Care	1,147,281	32
33	General Administration	627,040	33
	B. Capital Expense		
34	Ownership	368,314	34
	C. Ancillary Expense		
35	Special Cost Centers	71,020	35
36	Provider Participation Fee	55,297	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,833,038	40
41	**Income before Income Taxes (line 30 minus line 40)****	(189,903)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (189,903)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Yet Filed If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Montgomery Nursing and Rehabilitation Ctr # 0039347 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,023	2,023	$ 43,576	$ 21.54	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,346	6,419	117,481	18.30	3
4	Licensed Practical Nurses	14,560	15,945	220,184	13.81	4
5	Nurse Aides & Orderlies	49,100	52,384	433,834	8.28	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,850	4,121	37,560	9.11	10
11	Social Service Workers	1,858	2,166	26,506	12.24	11
12	Dietician					12
13	Food Service Supervisor	1,577	2,853	25,253	8.85	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,514	18,123	118,604	6.54	15
16	Dishwashers					16
17	Maintenance Workers	4,220	4,404	38,401	8.72	17
18	Housekeepers	9,842	10,655	72,897	6.84	18
19	Laundry	8,411	8,775	49,741	5.67	19
20	Administrator	1,770	1,770	51,102	28.87	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,857	4,412	57,022	12.92	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,227	2,444	28,443	11.64	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	126,155	136,494	$ 1,320,604 *	$ 9.68	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	109	$ 4,974	1,3	35
36	Medical Director	N/A	8,800	9,3	36
37	Medical Records Consultant	16	714	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	N/A	830	10,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	44	2,365	11,3	44
45	Social Service Consultant	47	2,584	12,3	45
46	Other(specify) Advisory Board	N/A	1,250	10,3	46
47	Nursing Consultants	N/A	1,211	10,3	47
48					48
49	TOTAL (lines 35 - 48)	216	$ 22,728		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	Section N/A	$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Montgomery Nursing and Rehabilitation Ctr # 0039347 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jerry Nelson	Administrator	0.00	$ 6,231
Carla Vonder Haar	Administrator	0	22,134
Bliss Pfeifer	Administrator	0	22,737
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 51,102

B. Administrative - Other

Description		Amount
Wellington Management Company	Management Fees	$ 95,620
Health Care Finacial, L.L.C.	Management Fees	37,186
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)		$ 132,806

C. Professional Services

Vendor/Payee	Type	Amount
C.J. Schlosser & Company L.L.C.	Accounting Services	$ 27,838
Hughes & Associates, CPA	Audit Fees	4,934
Ted Frapolli	Legal Services	400
McMahon, Berger, Hanna, et al	Legal Services	2,191
Duane Morris	Legal Services	873
Adams & Wilson, PC	Legal Services	516
Newman, Freyman, Klein, et al	Legal Services	57
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 36,809

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 47,110
Unemployment Compensation Insurance	33,479
FICA Taxes	100,469
Employee Health Insurance	15,631
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Staff Relations	3,786
Employee Physicals	83
Employee Disability Insurance	200
Employee Dental Insurance	1,382
Home Office Employee Benefits	10,381
TOTAL (agree to Schedule V, line 22, col.8)	$ 212,521

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
Section N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	1,916
Health Care Worker Background Check (Indicate # of checks performed 58)	696
Dues , Subscriptions & Manuals	1,450
Licenses & Fees	345
Bank Service Charge	1,531
IHCA Dues	2,865
Home Office Dues, Fees & Subscriptions	572
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,575

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,767
Seminar Expense	1,773
Home Office Travel and Seminar	2,504
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,044

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing and Rehabilitation Ctr # 0039347 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	Section Not Applicable		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing and Rehabilitation Ctr # 0039347 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Association $2,865**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **None** Line **N/A**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **55,297**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **None**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **None** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **1,507**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **14.6%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **None**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm?
Firm Name: **Hughes & Associates** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Not yet complete**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

MONTGOMERY NURSING & REHABILITATION CENTER, INC.
RECLASSES
ATTACHMENT TO SCHEDULE V
12/31/02

DESCRIPTION	LINE #	INCREASE (DECREASE)
DUES, FEES, SUBSCRIPTIONS AND PROMOTIONS	20	138
NURSE AIDE TRAINING	13	15
TRAVEL AND SEMINAR	24	(153)
To reclass expenses for CNA class books and nursing manuals to proper line		
ADMINISTRATIVE	17	(478)
MAINTENANCE	6	228
NURSING & MEDICAL RECORDS	10	250
To reclass maintenance supplies & dental visits to proper line		
DUES, FEES, SUBSCRIPTIONS AND PROMOTIONS	20	(506)
NURSE AIDE TRAINING	13	506
To reclass CNA class expenses to proper lines		
RENT-EQUIP & VEHICLES	35	(126)
CLERICAL & GENERAL OFFICE EXPENSES	21	126
To reclass postage fees to proper line		

MONTGOMERY NURSING & REHABILITATION CENTER, INC.
MISCELLANEOUS INCOME
ATTACHMENT TO SCHEDULE XVII, PAGE 19, LINE 28
12/31/02

Cable Income	67
Medicare Billing Income	6,900
Seniorcise Program Income	850
Donations for Bird Aviary	4,542
Other Miscellaneous Income	961
	13,320

MONTGOMERY NURSING & REHABILITATION CENTER, INC.
TRAVEL AND SEMINAR SCHEDULE
ATTACHMENT TO SCHEDULE XIX PART G
12/31/2002

SEMINAR PARTICIPANT	JOB TITLE	DATE(S)	CITY	TITLE OF SEMINAR	SPONSOR	COST	SEMINAR LODGING/ TRAVEL/MEALS
Ann Amos	Director of Operations	6/6/2002	St. Louis, MO	Writing Resident Care Plans	Medical & Professional Seminars	45	
Mindy Pearse	MDS Coordinator	10/2/2002	Springfield, IL	MDS Basics	IHCA	90	
Mindy Pearse	MDS Coordinator	6/26/2002	Springfield, IL	MDS Advanced	IHCA	90	
Carla Vonder Haar	Administrator	2/19-2/20/02	Springfield, IL	IOC Provider Training	IHCA	100	
Ann Amos	Director of Operations	2/19-2/20/02	Springfield, IL	IOC Provider Training	IHCA	100	
Robin White	DON	2/19-2/20/02	Springfield, IL	IOC Provider Training	IHCA	100	
Ann Amos	Director of Operations	3/6/2002	Springfield, IL	Making the IOC Work for Your Facility	IHCA	90	
Bliss Pfeifer	Administrator	3/6/2002	Springfield, IL	Making the IOC Work for Your Facility	IHCA	70	
Birdie Scroggins	Activities Director	10/24-10/25/02	Decatur, IL	IAPA Convention	IAPA	155	175
Bliss Pfeifer	Administrator	6/26-6/27/02	East Peoria, IL	INHAA Conference	INHAA	65	72
Carla Vonder Haar	Administrator	10/10/2002	Springfield, IL	Nursing Home Administrators Certification Test	Continental Testing Services	456	
Dee Wells	CNA	9/2002		Alzheimers Seminar		25	
Barb Cass	CNA	9/2002		Alzheimers Seminar		25	
Stacy Payne	DON	9/2002		Alzheimers Seminar		25	
Various	Various	3/2002	Hillsboro, IL	CPR Class	Montgomery County CPR Instructors	30	
Various	Various	9/2002	Hillsboro, IL	CPR Class	Montgomery County CPR Instructors	30	
Ann Amos	Director of Operations	7/2002	Springfield, IL		IHCA	30	
						1526	247

Total Seminar Lodging/Travel/Meals	247
Other Travel Expense <$250	1767
Home Office Travel & Seminar	2504
Total Travel & Seminar, Line 24	6044